

		FOR OHF USE					

LL 1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0005520</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>MOUNT ST. JOSEPH</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/01/03</u> to <u>6/30/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>24955 N. HWY 12</u> <u>LAKE ZURICH, IL</u> <u>60047</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>LAKE</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>SISTER SHARON WILLIAMS</u> (Title) <u>SUPERIOR</u>	
Telephone Number: <u>847-438-5050</u> Fax # <u>847-438-6313</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>	
IDPA ID Number: <u>36-2639774001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>1947</u>			
Type of Ownership:			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input checked="" type="checkbox"/> Charitable Corp.		<input type="checkbox"/> PROPRIETARY	
<input type="checkbox"/> Trust		<input type="checkbox"/> Individual	
IRS Exemption Code _____		<input type="checkbox"/> Partnership	
		<input type="checkbox"/> Corporation	
		<input type="checkbox"/> "Sub-S" Corp.	
		<input type="checkbox"/> Limited Liability Co.	
		<input type="checkbox"/> Trust	
		<input type="checkbox"/> Other _____	
In the event there are further questions about this report, please contact: Name: <u>DON LASCO</u> Telephone Number: <u>847-438-5050</u>			

STATE OF ILLINOIS

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Facility Name & ID Number MOUNT ST. JOSEPH# 0005520 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>132</u>	Intermediate/DD	<u>132</u>	<u>48,180</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	132	TOTALS	132	48,180	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>44,368</u>	<u>1,036</u>		<u>45,404</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,368	1,036		45,404	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.24%

D. How many bed-hold days during this year were paid by Public Aid?

2,022 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 1947

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/04 Fiscal Year: 6/30/04

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

MOUNT ST. JOSEPH

0005520

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	113,692		4,510	118,202		118,202	(11,820)	106,382		1
2	Food Purchase		184,424		184,424		184,424	(18,424)	166,000		2
3	Housekeeping	205,059	16,761		221,820		221,820		221,820		3
4	Laundry	32,965	9,870		42,835		42,835		42,835		4
5	Heat and Other Utilities			192,471	192,471		192,471	(9,624)	182,847		5
6	Maintenance	195,340	44,801	276,175	516,316		516,316		516,316		6
7	Other (specify):* FARM	18,601		1,662	20,263		20,263	(20,263)			7
8	TOTAL General Services	565,657	255,856	474,818	1,296,331		1,296,331	(60,131)	1,236,200		8
	B. Health Care and Programs										
9	Medical Director	30,686			30,686		30,686		30,686		9
10	Nursing and Medical Records	1,883,602	40,599	63,798	1,987,999	(20,650)	1,967,349		1,967,349		10
10a	Therapy	162,371		6,857	169,228	(6,857)	162,371	(6,000)	156,371		10a
11	Activities										11
12	Social Services	83,649	387		84,036		84,036		84,036		12
13	Nurse Aide Training					20,650	20,650		20,650		13
14	Program Transportation		21,995		21,995		21,995		21,995		14
15	Other (specify):* DAY TRAINING	250,675	11,841	117,119	379,635		379,635	(379,635)			15
16	TOTAL Health Care and Programs	2,410,983	74,822	187,774	2,673,579	(6,857)	2,666,722	(385,635)	2,281,087		16
	C. General Administration										
17	Administrative	103,620	23,282	29,614	156,516		156,516		156,516		17
18	Directors Fees										18
19	Professional Services			97,582	97,582		97,582		97,582		19
20	Dues, Fees, Subscriptions & Promotions			27,754	27,754		27,754		27,754		20
21	Clerical & General Office Expenses	126,555	31,893	8,711	167,159		167,159		167,159		21
22	Employee Benefits & Payroll Taxes			521,750	521,750		521,750	(17,710)	504,040		22
23	Inservice Training & Education										23
24	Travel and Seminar			620	620		620		620		24
25	Other Admin. Staff Transportation		1,297		1,297		1,297		1,297		25
26	Insurance-Prop.Liab.Malpractice			84,462	84,462		84,462		84,462		26
27	Other (specify):*										27
28	TOTAL General Administration	230,175	56,472	770,493	1,057,140		1,057,140	(17,710)	1,039,430		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,206,815	387,150	1,433,085	5,027,050	(6,857)	5,020,193	(463,476)	4,556,717		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number **MOUNT ST. JOSEPH**

#0005520

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			276,757	276,757		276,757	16,840	293,597			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(213,600)	(33,600)			34
35	Rent-Equipment & Vehicles					6,857	6,857		6,857			35
36	Other (specify):*											36
37	TOTAL Ownership			456,757	456,757	6,857	463,614	(196,760)	266,854			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			333,408	333,408		333,408		333,408			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			333,408	333,408		333,408		333,408			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,206,815	387,150	2,223,250	5,817,215		5,817,215	(660,236)	5,156,979			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

STATE OF ILLINOIS

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Facility Name & ID Number MOUNT ST. JOSEPH

0005520

Report Period Beginning:

7/1/2003

Ending:

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(30,244)	L 1&2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(33,600)	L 34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(64,171)	L 30		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(6,000)	L 10a		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals	(379,635)	L 15		23
24	Bad Debt	(16,477)	L 22		24
25	Fund Raising, Advertising and Promotional	(1,233)	L 22		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(20,263)	L 7		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(9,624)	L 5		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (561,247)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(98,989)	VII L14	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (98,989)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (660,236)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

MOUNT ST. JOSEPH

ID# 0005520

Report Period Beginning: 7/01/03

Ending: 6/30/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2				2
3				3
4	NON-PATIENT MEALS	(30,244)	L 1&2	4
5				5
6	RENTED FACILITY SPACE	(33,600)	L 34	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14	DEPRECIATION	(64,171)	L 30	14
15				15
16				16
17	PRIEST STIPEND	(6,000)	L 10a	17
18				18
19				19
20				20
21				21
22				22
23	DAY TRAINING	(379,635)	L 15	23
24	PAYROLL TAX DAY TRAINING	(16,477)	L 22	24
25	PAYROLL TAX FARM	(1,233)	L 22	25
26	FARM	(20,263)	L 7	26
27				27
28	UTILITIES	(9,624)	L 5	28
29				29
30	SUBTOTAL (A):	(561,247)		30
31				31
32				32
33				33
34	RELATED ORGANIZATION COSTS	-98,989		34
35				35
36	SUBTOTAL (B):	-98,989		36
37	TOTAL ADJUSTMENTS	-660,236		37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,980,708)		49

Summary A

6/30/04

6/30/04

[illegible]

Summary B

6/30/04

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DAUGHTER,S OF ST. MARY OF PROVIDENCE	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 RENT	\$ (180,000)	DAUGHTER,S OF ST. MARY OF PROVIDENCE	100.00%	\$	\$ 180,000 1
2	V	30 DEPRECIATION	81,011	DAUGHTER,S OF ST. MARY OF PROVIDENCE	100.00%		(81,011) 2
3	V						3
4	V						4
5	V						5
6	V						6
7	V						7
8	V						8
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ (98,989)			\$	\$ * 98,989 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SISTER SHARON WILLIAM	SUPERIOR	C.E.O.			84	100.00	SALARY	\$ 58,620	L 17 C 1	1
2	SR. MARGARET SCHISLE	ADMINISTRATOR	TREASURER			84	100.00	SALARY	45,000	L 17 C1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 103,620		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/1/2003 Ending: #####

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization N/A
 Street Address _____
 City / State / Zip Code _____
 Phone Number ()
 Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1	N/A			N/A			\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$	\$			\$	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$	\$			\$	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$	Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)**

Facility Name & ID Number **MOUNT ST. JOSEPH**# **0005520** Report Period Beginning: **7/1/2003** Ending: **6/30/2004****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.		\$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$ #VALUE!	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ #VALUE!	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1999	8	
	2000	9	
	2001	10	
	2002	11	
	2003	12	
			FOR OHF USE ONLY
			13 FROM R. E. TAX STATEMENT FOR 2003 \$ 13
			14 PLUS APPEAL COST FROM LINE 5 \$ 14
			15 LESS REFUND FROM LINE 6 \$ 15
			16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME MOUNT ST. JOSEPH COUNTY LAKE
FACILITY IDPH LICENSE NUMBER 0005520
CONTACT PERSON REGARDING THIS REPORT _____
TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

A. Square Feet:

147,565

B. General Construction Type:

Exterior

BRICK

Frame

BRICK

Number of Stories

2

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

DEVELOPMENTAL TRAINING 1,010 SQ. FEET

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	HOME & FARM	160 ACRES OR	1935	\$ 8,000	1
2		6,969,600 SQ. FEET			2
3	TOTALS	#VALUE!		\$ 8,000	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	132			1969	\$ 5,007,009	\$		\$	\$	\$ 5,007,009	4
5											5
6				1990	2,361,653	78,720	30	78,720		1,141,442	6
7				1990	68,729	2,290	30	2,290		33,205	7
8											8
	Improvement Type**										
9	LAND IMPROVEMENTS-PRIOR YEARS			1993	29,005						9
10				1994	93,489						10
11				1995	44,713						11
12				1996	18,082						12
13				1997	42,570						13
14				1998	17,423						14
15				1999	21,853						15
16				2001	4,700	15,843		15,843		197,502	16
17											17
18	BUILDING IMPROVEMENTS-PRIOR YEARS			1991	74,205						18
19				1992	90,293						19
20				1993	180,181						20
21				1994	178,251						21
22				1995	231,228						22
23				1996	82,875						23
24				1997	71,814						24
25				1998	116,448						25
26				1999	121,823						26
27				2000	37,015	158,146		158,146		965,500	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,893,359	\$ 254,999		\$ 254,999	\$	\$ 7,344,658	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,893,359	\$ 254,999		\$ 254,999		\$ 7,344,658	1
2	BUILDING IMPROVEMENTS:								2
3	EVAPORATOR COIL-KITCHEN	Jul-00	2,400						3
4	BOILER GASKET	Aug-00	2,508						4
5	HEAT EXCHANGER	Aug-00	2,697						5
6	PLASTER SWINNING POOL	Nov-00	14,680						6
7	SERVICE COOLER COIL-KITCHEN	1-Jan	3,900						7
8	PUMP-ST. ALS	1-Jan	2,094						8
9	SHOWER CABINET	1-Jan	5,550						9
10	REPAIRS-DAY ROOM	1-Jan	9,573						10
11	WINDOW BLINDS	1-Mar	3,500						11
12	DOUBLE OVEN-KITCHEN	1-Apr	7,950						12
13	COMPRESSOR-POOL	1-Apr	13,600						13
14	WINDOW BLINDS	1-Apr	3,500						14
15	ROOF CABLES-THERAPY	1-Jun	4,860						15
16									16
17	ROOF REPAIR	1-Jul	10,036						17
18	SEWER LINE REPAIR	1-Sep	23,771						18
19	MUDRINK TANK REPAIR	1-Sep	2,170						19
20	A/C COMPRESSOR & CHILLER	1-Oct	12,700						20
21	DOOR REPLACEMENT	1-Oct	6,730						21
22	REPLACE SUBMERSIBLE WELL PUMP	1-Oct	11,995						22
23	PLUMBING WORK	1-Dec	27,162						23
24	SPEED CONTROL REPLACEMENT	2-Apr	3,722						24
25	PLUMBING WORK	2-May	4,500						25
26	LIGHTING-POOL	2-May	5,800						26
27	REPAIR DRY SYSTEM PIPE	2-Jun	3,500						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,082,257	\$ 254,999		\$ 254,999		\$ 7,344,658	34

**Improvement type must be detailed in order for the cost report to be considered complete.

6/30/2004

****Improvement type must be detailed in order for the cost report to be considered complete.**

6/30/2004

****Improvement type must be detailed in order for the cost report to be considered complete.**

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,173,525	\$ 36,264	\$ 36,264	\$		\$ 1,063,921	71
72	Current Year Purchases	4,350						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,177,875	\$ 36,264	\$ 36,264	\$		\$ 1,063,921	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT TRANSPORT	02 FORD VAN	2002	\$ 23,334	\$ 2,334	\$ 2,334	\$	10	\$ 7,002	76
77										77
78										78
79										79
80	TOTALS			\$ 23,334	\$ 2,334	\$ 2,334	\$		\$ 7,002	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,943,688	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 293,597	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 293,597	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,415,581	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	FARM EQUIPMENT	\$ 40,316	\$	\$ 40,316	86
87	VEHICLES	443,474	28,640	299,143	87
88	NON-CARE	1,052,810	35,531	864,558	88
89					89
90					90
91	TOTALS	\$ 1,536,600	\$ 64,171	\$ 1,204,017	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 6,857

Description: COPY MACHINES

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE <u>40</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE <u>80</u>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	3,850	5,600		9,450
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation		11,200		11,200
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 3,850	\$ 16,800	\$	\$ 20,650
10	SUM OF line 9, col. 1 and 2 (e)	\$ 20,650			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	15

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	9/1	visits	28,286					28,286	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 28,286		\$	\$		\$ 28,286	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,764,265	\$ 1,764,265	1
2	Cash-Patient Deposits	75,529	75,529	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	453,473	453,473	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	52,541	52,541	5
6	Prepaid Insurance	71,513	71,513	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,417,321	\$ 2,417,321	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		8,000	13
14	Buildings, at Historical Cost		7,437,391	14
15	Leasehold Improvements, at Historical Cost	1,596,954	3,498,297	15
16	Equipment, at Historical Cost		2,737,809	16
17	Accumulated Depreciation (book methods)		(8,479,752)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,596,954	\$ 5,201,745	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,014,275	\$ 7,619,066	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 156,657	\$ 156,657	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	94,753	94,753	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	327,494	327,494	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 578,904	\$ 578,904	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 578,904	\$ 578,904	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,435,371	\$ 7,040,162	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,014,275	\$ 7,619,066	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,477,160	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,477,160	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	958,211	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 958,211	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,435,371	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,833,059	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,833,059	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	33,600	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 33,600	23
D. Non-Operating Revenue			
24	Contributions	503,956	24
25	Interest and Other Investment Income***	10,385	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 514,341	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a		434,791	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 434,791	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,815,791	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,296,331	31
32	Health Care	2,666,722	32
33	General Administration	1,057,140	33
B. Capital Expense			
34	Ownership	463,614	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	333,408	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,817,215	40
41	Income before Income Taxes (line 30 minus line 40)**	958,211	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 958,211	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **MOUNT ST. JOSEPH**# **0005520**Report Period Beginning: **7/1/2003**

Ending:

6/30/2004**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	37,091	37,288	518,309	13.90	3
4	Licensed Practical Nurses	4,891	5,084	64,824	12.75	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,565	4,760	52,502	11.03	9
10	Activity Assistants	13,918	14,068	109,869	7.81	10
11	Social Service Workers	5,379	5,577	83,649	15.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	6,593	6,708	50,310	7.50	14
15	Cook Helpers/Assistants	9,165	9,280	63,382	6.83	15
16	Dishwashers	19,867	20,167	250,675	12.43	16
17	Maintenance Workers	20,794	20,892	195,340	9.35	17
18	Housekeepers	24,256	24,706	205,059	8.30	18
19	Laundry	4,240	4,320	32,965	7.63	19
20	Administrator	3,994	4,034	58,620	14.53	20
21	Assistant Administrator	4,329	4,369	45,000	10.30	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,753	11,053	126,555	11.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	1,773	1,798	30,686	17.07	27
28	Qualified MR Prof. (QMRP)	15,678	15,803	182,524	11.55	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	57,357	59,057	1,076,025	18.22	30
31	Medical Records					31
32	Other Health C: PSYCHOLOGY	2,967	3,012	41,920	13.92	32
33	Other(specify) FARM	2,012	2,037	18,601	9.13	33
34	TOTAL (lines 1 - 33)	249,622	254,013	\$ 3,206,815 *	\$ 12.62	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	82	\$ 4,510	L 1 C 3	35
36	Medical Director				36
37	Medical Records Consultant	103	4,128	L 10 C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	62	3,413	L 10 C 3	40
41	Occupational Therapy Consultant	56	3,206	L 10 C 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) DENTIST	334	16,707	L 10 C 3	46
47	PSYCHOLOGIST	876	35,039	L 10 C 3	47
48	PODIATRIST	22	1,305	L 10 C 3	48
49	TOTAL (lines 35 - 48)	1,535	\$ 68,308		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Ending: 6/30/2004

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	620
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 620

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number MOUNT ST. JOSEPH

0005520

Report Period Beginning: 7/1/2003

Ending:

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,662 Line L 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 333,408
This amount is to be recorded on line 42 of Schedule V. _____
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? YES NUNS QUARTEL For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions. _____
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 6,709
c. What percent of all travel expense relates to transportation of nurses and patients? 10%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: FOLISI, SAMZ, & CO. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees. _____

MOUNT ST. JOSEPH 0005520 7/1/03-6/30/04

V. COST CENTER EXPENSES RECLASSIFICATION PAGE 3

FROM V. LINE 10	-20,650
TO V. LINE 13	20,650
RECLASSIFY NURSE AIDE TRAINING	

FROM V. LINE 10a	-6,857
V. LINE 35	6,857
RECLASSIFY RENT-EQUIPMENT	

V. COST CENTER EXPENSES OTHER PAGE 3

FARM	SALARIES	18,601
FARM	OTHER BENEFITS	1,662
FARM	PAYROLL TAXES	1,233
TOTAL		21,496

V. COST CENTER EXPENSES OTHER PAGE 3

DAY TRAINING	SALARIES	250,675	
DAY TRAINING	SUPPLIES	11,841	
DAY TRAINING	BENEFITS	25,639	
	OCCUPANCY	33,170	
	TRANSPORT	51,825	
	RENT	2,555	
	DEPRECIATION	3,930	117,119
DAY TRAINING	PAYROLL TAXES	16,477	
TOTAL		396,112	

MOUNT ST. JOSEPH 5520 7/01/03-6/30/04

VI. ADJUSTMENT DETAIL PAGE 5

DIETARY V. LINE 1	V. LINE 1	118,202 X 10 = (11,820)	
FOOD PURCHASE	V. LINE 2	184,424 X 10 = (18,424)	-30,244
UTILITIES	V. LINE 5		-9,624
FARM	V. LINE 7		-20,263
PRIEST STIPEND	V. LINE 10a		-6,000
DAY TRAINING	V. LINE 15		-379,635
DAY TRAINING	V. LINE 22 TAX	-16,477	
FARM	V. LINE 22 TAX	-1,233	-17,710
DEPRECIATION	V. LINE 30		-64,171
RENTED SPACE	V. LINE 34		-33,600
SUBTOTAL (A):			-561,247
RELATED PARTY COST			-98,989
TOTAL ADJUSTMENTS (A) AND (B)			-660,236

VI. ADJUSTMENT DETAIL / UTILITIES PAGE 5 SQUARE FOOTAGE

CARE RELATED AREA:

THERAPEUTIC CENTER	29,450
FRAME HOUSE	6,770
ADMINISTRATIVE BUILDING	6,890
NOVITIATE & AUDITORIUM	11,120
ANGEL GUARDIAN	9,582
BOILER & LAUNDRY	4,690
CHAPEL	12,468
GARAGE	1,912
ST. MARY,S	11,691
JOSEPH,S	9,464
PASSAGEWAY	5,392
ST. ALOYIOUS	9,270
GUANELLA	15,887
KITCHEN	5,749
GARAGE	660
CHAPLAIN,S HOUSE	4,022
ADMINISTRATIVE BUILDING 2nd FLOOR	3,445
TOTAL	147,565

NON-CARE RELATED AREA

NOVITIATE & AUDITORIUM	5,560
FARM HOUSE	1,768
TOTAL	7,328
TOTAL SQUARE FOOTAGE	154,893
NON-CARE AREA 7,328/ 154,893	0.05
TOTAL UTILITIES LINE 5 PAGE 3	192,471
TOTAL NON-CARE RELATED UTILITIES=	X.05 9,624

MOUNT ST. JOSEPH	5520	7/01/03-6/30/04
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XVII. INCOME STATEMENT OTHER REVENUE	PAGE 19
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DEVELOPMENTAL TRAINING LINE 28a	434,791
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MOUNT ST. JOSEPH	5520	7/01/03-6/30/04
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XVIII. STAFFING AND SALARY COSTS	PAGE 20
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DEVELOPMENTAL TRAINING	LINE 16	250,675
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PSYCHOLOGY	LINE 32	41,920
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FARM	LINE 33	18,601
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